GAO

United States General Accounting Office

Report to Congressional Committees

November 1988

MEDICARE

Incentives Needed to Assure Private Insurers Pay Before Medicare

GAO

United States
General Accounting Office
Washington, D.C. 20548

Human Resources Division

B-219892

November 29, 1988

The Honorable Lloyd Bentsen
Chairman, Committee on Finance
United States Senate

The Honorable John D. Dingell
Chairman, Committee on Energy and Commerce
House of Representatives

The Honorable Dan Rostenkowski
Chairman, Committee on Ways and Means
House of Representatives

One way to help control rising Medicare costs is to be sure that the program does not pay medical bills that other insurers should cover. Several times since 1980, the Congress has amended the Medicare statute to designate certain insurers as the primary payer—that is, to require them to pay medical claims ahead of Medicare. Insurers become the primary payer if they provide medical coverage to Medicare beneficiaries under certain employer group insurance plans, workers' compensation, or automobile and other liability insurance. Medicare then acts as a secondary payer; its claims processing contractors, usually themselves insurance firms, pay only what Medicare is responsible for after the other insurance pays. An estimated 1.5 million Medicare beneficiaries (about 5 percent) have other such insurance.

Results in Brief

Medicare saved about $1.4 billion in fiscal year 1987 by paying beneficiaries' medical bills only after other responsible insurers had paid. But further savings were not achieved because many other such "dual coverage" claims were not identified (see p. 11). Neither the Medicare contractors that pay claims nor the other insurers covering Medicare beneficiaries have financial incentives to help ensure that Medicare pays after any other primary payer. It is unlikely that Medicare's secondary payer provisions will achieve all possible savings until the program gives contractors and insurers incentives to comply, as we recommended previously.[1] This has not been done, although Medicare has taken steps to improve the data available for identifying dual-coverage claims.

[1] Medicare: More Hospital Costs Should Be Paid by Other Insurers (GAO/HRD-87-43, Jan. 29, 1987).

Background

The Health Care Financing Administration (HCFA), an agency of the Department of Health and Human Services (HHS), administers Medicare. HCFA relies on its contractors to assure that erroneous payments are not made. Medicare contractors were allotted a total of $115 million in fiscal years 1987 and 1988 to identify claims for which other insurers are responsible and to see that these insurers pay ahead of Medicare. For example, the contractors must use mail questionnaires to identify new beneficiaries with other insurance coverage, keep computerized files on them, and use these files to screen claims they process.

In 1987, we reported that Medicare's processes for assuring hospital claims were paid by other insurers were not as effective as they could be and that at least $527 million had been paid in error in 1985. The root of the problem was that insurers lacked incentives to comply with the secondary payer provisions; indeed they had an incentive to avoid primary payments because such action reduced their expenses. Moreover, they faced no penalty if they were found to be avoiding primary payment.[2]

Also, Medicare claims processing contractors—themselves insurers—had no incentives (beyond a minimum, easy-to-achieve level set by Medicare) to identify claims for which Medicare was secondary. Like the other insurers, they had an incentive to pay after Medicare for beneficiaries who also were covered by their lines of private insurance.

We made recommendations and proposals to HCFA and the Congress aimed at strengthening incentives for insurers and contractors. For example, Medicare's contractors were not always acting on information that identified claims that should have been paid primary to Medicare but were not. Thus, we recommended that HCFA increase the performance standards so that contractors found not acting on available information would be rated unsatisfactory and required to improve or risk losing their Medicare contracts. Also, upon finding that certain employer-sponsored insurers were structuring their coverage of Medicare beneficiaries to avoid primary payments, we proposed two options for the Congress to consider. These were to either (1) penalize insurers failing to comply with Medicare requirements or (2) direct that regulations be promulgated to strengthen program enforcement mechanisms.

[2]However, the government can recover damages from certain employer-sponsored health plans that do not pay claims involving disabled beneficiaries before Medicare. This authority is limited because implementing regulations have not been issued (see pp. 13-15).

Because of the potential for significant savings to the government, we reviewed actions taken by HCFA and its contractors in response to our 1987 report. We examined current incentives and controls that help assure that Medicare always acts as secondary payer when other insurers have primary responsibility. To do so, we reviewed Medicare contractors operating in New Jersey, Ohio, Oregon, and Washington.

Principal Findings

While significant savings have been achieved, HCFA has reported that implementation has fallen short of its expectations. Proposed HCFA regulations published in the Federal Register on June 15, 1988, stated that savings are lost because many Medicare secondary payer claims are not identified as such. This is consistent with what we reported last year. Medicare still is paying many claims that other insurers should pay. While Medicare has taken steps to improve the information available for identifying claims for which Medicare was secondary, insurers and contractors do not have adequate incentives to comply. Until they have such incentives, Medicare secondary payer provisions will not achieve all possible savings.

Contractor Incentives Still Lacking

HCFA has not acted on our recommendations to strengthen its evaluation standards for contractor performance, so as to increase contractors' incentives to improve their performance in identifying and properly billing other insurers. Our latest review found contractors not using available information to collect on claims that other insurers should have paid ahead of Medicare but did not. For example:

1. In June 1986, the HHS Inspector General gave a contractor a list of $548,365 in Medicare claims it had erroneously paid over a 26-month period. The contractor did not begin to seek recoveries from the primary insurers until the day before our visit to that contractor in January 1988.

2. HCFA estimated that one of its largest contractors, also a major independent health insurance company in its state, had not reimbursed Medicare for about $10 million in erroneous claims. The contractor's private business should have, but did not, pay these claims before Medicare. According to HCFA, the contractor did not follow HCFA procedures to maintain an audit trail for these claims, making it difficult to retrace the contractor's review of such claims to assure that Medicare recovered all amounts due.

Clearly, both contractors could have saved the Medicare program substantially more than they did in fiscal year 1987. Yet HCFA rated both "fully successful" under its contractor evaluation standards, based on HCFA-established goals for annual contractor savings. In our opinion, the goals were easy to meet, and once met, contractors had little incentive to pursue additional savings (see p. 19).

In 1987, HCFA funded several initiatives to improve the data available for contractors to identify and bill other insurers (see p. 15). As our examples show, however, better data alone will not necessarily produce better results. HCFA also should require contractors to maintain the new data systems and use the data to prevent or recover erroneous payments. Although start-up problems are expected when new initiatives are implemented, the continued lack of contractor incentives to make the initiatives work remains a problem. While we cannot separate start-up problems from those related to limited incentives, we found that HCFA contractors

- submitted incomplete and/or inaccurate data for inclusion in the system's database,
- failed to use available data to identify and seek recoveries for erroneously paid claims, and
- did not follow HCFA requirements for obtaining data on new beneficiaries' insurance coverage before paying claims.

No Penalties for Errant Insurers

Insurers that do not pay beneficiaries' medical bills appropriately as the primary payer face no penalty and save themselves money by not doing so. Consequently, insurers have little incentive to establish internal controls to help assure that they pay ahead of Medicare. For example:

1. One insurer had a written procedure requiring that claims be paid secondary to Medicare regardless of the insurer's known primary liability. Under this procedure, only when the Medicare contractor specifically advised this private insurer that Medicare was the secondary payer would the insurer pay first.

2. Another insurer refused to make primary payments because it disagreed with HCFA's interpretation of insurers' responsibilities under Medicare's secondary payer law and regulations. In effect, the insurer adopted the position that it would not pay primary to Medicare (or reimburse Medicare) if the employer-sponsored plan it was underwriting did not contain specific provisions allowing for such primary payments. In

essence, the insurer was offering its employer-sponsored plans the option to cover working aged beneficiaries with either primary or secondary coverage. HCFA regulations do not recognize any policies covering such beneficiaries as secondary to Medicare. To recognize such policies would negate the purpose of the Medicare secondary payer statutes and eliminate the prospect of achieving the intended program savings. As this insurer is among the largest in the country, its position can have a substantial effect on Medicare savings. Consequently, in April 1988, the HCFA Administrator asked the HHS Inspector General to investigate this insurer.

Because HCFA generally can recover only amounts paid in error, insurers that adopt policies that hinder Medicare's efforts to obtain payment from the liable insurer face little financial risk. In fact, insurers with such policies achieve the financial benefit of delaying payments on claims for which they are primary or avoiding them entirely if Medicare fails to discover the claims.

To give insurers incentives to pay appropriately as the primary payer, in 1987 the House of Representatives passed a bill that included a provision giving HCFA a regulatory basis to recover twice the amount owed from any insurer that did not pay first when it was a beneficiary's primary insurer. This provision was omitted from the enacted legislation without explanation. Such a provision would give HCFA a means to impose a cost on insurance companies not complying with Medicare requirements and, thus, serve as a deterrent to noncompliance (see p. 12). Medicare statutes already allow HCFA to recover twice the amount owed from insurers covering disabled Medicare beneficiaries.

Recommendations

To strengthen contractor and other insurer incentives that help assure that Medicare does not pay first when beneficiaries have dual coverage, we recommend that

- the Congress, as proposed by the House in 1987, amend the Social Security Act to establish the government's right to collect twice the amounts owed from insurers that do not properly treat Medicare as the secondary payer and
- the Secretary of HHS direct the Administrator of HCFA to establish standards for use in evaluating the effectiveness with which contractors implement and use the data systems, processes, and controls HCFA designed to prevent Medicare from erroneously paying as the primary payer.

Additional details on our findings and recommendations are contained in appendix I. Recommended language for amending the Social Security Act appears in appendix II.

Agency Comments

HHS said it strongly supported our recommendations to provide enhanced incentives for providers and insurers to properly identify claims for which Medicare is the secondary payer. HHS included GAO's legislative proposal in draft legislation that was sent to the Congress in August 1988. HHS also noted that action was initiated to evaluate contractor use of secondary payer data systems and that validation reviews were expected to begin during 1989. Although HHS did not address whether this action would become a part of the Contractor Performance Evaluation Program, as we specifically recommend in appendix I, such action should enhance contractor compliance. (See app. III.)

We are sending copies of this report to the Director of the Office of Management and Budget, the Secretary of HHS, the Administrator of HCFA, and other interested parties, and we will make copies available to others on request.

This report was prepared under the direction of Michael Zimmerman, Senior Associate Director. Other major contributors are listed in appendix IV.

Lawrence H. Thompson
Assistant Comptroller General

Contents

Abbreviations

CPEP	Contractor Performance Evaluation Program
HCFA	Health Care Financing Administration
HHS	Department of Health and Human Services
IG	Inspector General
OBRA	Omnibus Budget Reconciliation Act of 1987
RDES	Regional Data Exchange System

Medicare: Incentives Needed to Assure Private Insurers Pay Before Medicare

Background

The Medicare program, authorized by title XVIII of the Social Security Act effective July 1, 1966, helps pay medical costs for about 28 million people 65 years and older and about 3 million disabled people. Medicare part A covers inpatient hospital services, home health services, and other institution-based services. Part B covers physician, outpatient hospital, and various other health services, such as diagnostic tests. In fiscal year 1988, Medicare is expected to spend about $79 billion.

Between 1980 and 1986, the Congress established Medicare as the secondary payer to certain other insurers, aiming to reduce Medicare costs without materially affecting beneficiary services. About 5 percent of all Medicare beneficiaries (or 1.5 million persons)[1] have insurance coverage that is required to pay their medical bills ahead of Medicare. Insurance that must pay first includes certain employer-sponsored group health insurance policies available to working beneficiaries or working spouses, automobile and other liability insurance, and workers' compensation.

Overall responsibility for administering the secondary payer provisions lies with the Department of Health and Human Services (HHS). Within HHS, the Health Care Financing Administration (HCFA) develops policies and is responsible for ensuring compliance with Medicare legislation and regulations. HCFA itself does not process and pay Medicare claims, but contracts with insurance companies, such as local Blue Cross and Blue Shield plans, to do so. Contractors that process and pay part A claims are termed intermediaries; contractors that process and pay part B claims are called carriers.

HCFA develops procedures for its contractors to follow in identifying insurers that should pay before Medicare. Generally, when Medicare beneficiaries have such insurance, the providers of services (e.g., hospitals and physicians) are required to bill the primary insurers first. The insurers pay up to the limits of their coverages, and Medicare pays any remaining amounts for which it may be responsible (i.e., Medicare acts as secondary payer). To assure that these claims are paid correctly and recover moneys they paid previously in error, Medicare contractors are responsible for identifying and keeping records of beneficiaries having alternative primary insurance coverage. As part of their overall budgets, Medicare contractors were allocated a total of about $115 million for fiscal years 1987 and 1988 to administer the secondary payer provisions of the law.

[1] Based on estimates by HCFA and the Congressional Budget Office.

Although contractors reported to HCFA that Medicare saved over $1.4 billion in fiscal year 1987 by paying secondary to primary insurers, significantly more savings are possible. For example:

- A HCFA document submitted to the Office of Management and Budget estimated that an additional $400 million in fiscal year 1990 program costs could be saved by improving the flow of information on Medicare beneficiaries' health insurance coverage and strengthening HCFA's ability to enforce Medicare's role as secondary payer.
- A HCFA draft study of September and December 1986 hospital visits and related medical bills from 91 randomly selected hospitals in 16 states showed that these hospitals erroneously billed and Medicare paid, or had scheduled for payment, about $669,000 as primary payer when Medicare's liability was secondary.

Objectives, Scope, and Methodology

In January 1987, we reported (see p. 1) that HCFA erroneously paid at least $527 million in Medicare hospital claims in 1985 that should have been paid by other insurers. Because we and others, over the last 2 years, have reported that significant savings are not being realized under Medicare's secondary payer program, we conducted a follow-up review to our 1987 report. To assess the progress in resolving problems leading to the erroneous payments, we limited our review objectives to determining the extent to which

- contractors had incentives to improve controls that help assure that Medicare pays first only when other primary insurance is not available and
- legislation gave insurers incentives to pay Medicare beneficiary claims ahead of Medicare.

To accomplish our first objective, we focused on initiatives HCFA adopted in early 1987 to improve its contractors' ability to identify beneficiaries with primary insurance coverage and apply such coverage to their Medicare claims. Central to these initiatives was the establishment of the Regional Data Exchange System (RDES). This system gave contractors a uniform method of collecting, updating, and sharing their information on Medicare beneficiaries' insurance coverage with other contractors. Using RDES information to screen future claims, contractors were to recover previous Medicare primary payments made in error.

Accordingly, we reviewed HCFA's documents on RDES, including instructions to contractors. Also, we examined reports on the extent of contractor participation. For information on the usefulness and accuracy of the exchanged data, we relied on five contractors in four regions.

We also reviewed the method HCFA uses to monitor and measure contractor performance in fulfilling its secondary payer responsibilities. Specifically, we examined the segments of HCFA's Contractor Performance Evaluation Program (CPEP) that set standards for contractor performance in using Medicare as the secondary payer. We interviewed HCFA officials responsible for administering the secondary payer program.

In addition, we visited Medicare part A contractors in Ohio and Washington and part B contractors in New Jersey, Oregon, and Washington.

To accomplish our second objective, we reviewed applicable statutes and legislative history to determine the extent to which legislation gave insurers an incentive to pay beneficiaries' claims ahead of Medicare.

We performed our fieldwork between June 1987 and January 1988, in accordance with generally accepted government auditing standards. HHS provided written comments on a draft of this report, which are presented in appendix III.

Legislative Change Could Strengthen Insurer Incentives

When a Medicare beneficiary also has private insurance coverage, both Medicare and the insurers may receive a bill for services. In such instances, it is to the insurer's advantage to wait until Medicare denies the claim before paying. If Medicare erroneously pays the claim as primary payer, the other insurer will potentially pay less than it should. If Medicare denies the claim, the insurer's liability is no greater than if the insurer initially paid as the primary payer.

Although this payment practice may not be widespread among private insurers, HCFA provided one example of an insurer's written procedures requiring that it pay claims secondary to Medicare regardless of the insurer's known primary liability. Only when the Medicare contractor advises the private insurer that Medicare is the secondary payer does the procedure direct the insurer's claims offices to pay primary to Medicare.

Other examples also show that insurers have little incentive to pay primary to Medicare. In April 1988, the Administrator of HCFA advised the

HHS Inspector General (IG) that HCFA was having trouble getting two large Blue Cross/Blue Shield plans to make primary payments or satisfactorily explain why such payments were not made.

1. One insurer formally advised HCFA that it did not agree with HCFA's interpretation of Medicare law concerning the responsibilities of employer group health plans to pay primary to Medicare. In effect, the insurer adopted a position that (1) it would not pay primary to Medicare for an employer-sponsored plan unless the plan contained a provision specifically allowing for such primary payment and (2) if HCFA identified claims from such plans and sought primary payment, the insurer would not reimburse Medicare. In essence, the insurer was offering its employer-sponsored plans the option to cover working aged beneficiaries with either primary or secondary coverage. Based on existing law, HCFA does not recognize any policies covering such beneficiaries as secondary to Medicare. To do so would negate the purpose of the Medicare secondary payer statutes and eliminate the prospect of achieving the intended program savings. As this insurer is among the largest in the country, its position can have a substantial effect on Medicare savings.

2. Another insurer gave HCFA no satisfactory explanation of why the insurer had not reimbursed Medicare for an estimated $10 million because Medicare had erroneously paid first when the insurer was the primary payer.

In his letter the Administrator requested that the IG initiate audits of both these insurers (which are also Medicare contractors) to determine the amounts owed Medicare. According to a HCFA official, these audits will serve as the basis for HCFA to decide whether to initiate legal actions. Even if the government prevails and recovers the amounts erroneously paid by Medicare, the insurer has little loss other than its legal expenses, which may be offset by the financial advantages of delaying primary payment and the inability of the government to detect all instances where the insurer was the primary payer.

The Congress first addressed the issue of insurer incentives in the Omnibus Budget Reconciliation Act of 1986. This act amended the Social Security Act, effective January 1, 1987, to make large employer-sponsored group health plans (i.e., plans with at least one contributing employer that had 100 or more employees) that cover disabled beneficiaries primary payers to Medicare. This provision also authorizes the

government to recover damages based on twice the amount owed (double damages) from employer-sponsored group health plans that are primary payers but do not make primary payments. The amendment restricted the government rights to such double damages to claims involving disabled beneficiaries covered under large employer group health plans.

In our 1987 report, we proposed ways for the Congress to increase insurer incentives to properly treat Medicare as the secondary payer. For example, we found that some employer-sponsored insurance plans, contrary to congressional intent, were attempting to circumvent the secondary payer requirements by structuring their policies to exclude primary coverage for Medicare beneficiaries. To encourage compliance with statutory prohibitions against this practice, we asked the Congress to consider several options, one of which was to impose a tax on an employer's health plan premiums when policies do not meet Medicare secondary payer provisions.[2]

In 1987, the Congress again considered the double damage provision. An amendment in the House version of the Omnibus Budget Reconciliation Act of 1987 (OBRA) (H.R. 3545), section 4086, paragraph (o)(1), authorized the government to collect double damages on all Medicare claims subject to any secondary payer provision when the responsible insurer does not make primary payments. Although the OBRA conference report stated that these amendments in this House bill would be incorporated in the final version of the OBRA bill, the provision extending the government's right to collect double damages was not included.[3]

As a result, the use of double damages to penalize insurers that do not pay primary when they are supposed to is still restricted to claims for disabled Medicare beneficiaries. According to an HHS attorney, even for these claims the use of double damage authority has been limited,

[2]Similar requirements were already contained in legislation regarding employer-sponsored plans that exclude primary coverage of medical claims for disabled beneficiaries and persons with kidney failure.

[3]The conference report details the difference in the technical amendments in two sections of the House bill (sections 4086 and 9271). The report states that section 9271 contained several additional provisions not included in 4086, but that the remaining provisions were identical. This statement, however, was not accurate. While similar, the remaining provisions were not identical because the double damage provisions in section 4086(o) were not included in section 9271. However, apparently relying on the language in the conference report concerning technical provisions, the final version of the bill included only the section 9271 provisions, thus excluding the double damage provision contained in section 4086(o).

because regulations specifying when insurers should be subject to double damages have not yet been issued.

Incentives Needed to Improve Contractor Performance

Medicare contractors' ability to determine which claims are secondary to other insurance depends on their having accurate data on other insurance that covers each Medicare beneficiary. In this regard, HCFA has implemented a new and expanded data exchange system to facilitate the interchange and maintenance of a complete, current, and accurate database on beneficiaries known to have other insurance coverage. However, the effectiveness of the new system has been limited because HCFA contractors were not

- submitting complete data for inclusion in the system database,
- using available data to identify and seek recoveries for erroneously paid claims, and
- following HCFA requirements for obtaining data on new beneficiaries' insurance coverage before paying claims.

As we reported in 1987, contractors have little incentive to do all that they can to see that Medicare pays as secondary payer. HCFA's standards for evaluating contractor performance in applying Medicare secondary payer requirements have not changed since our report. These standards permit contractors to be rated successful even though they do not take all appropriate actions to identify and bill primary insurers.

HCFA's New Controls Have Marginal Success

In 1987, HCFA funded a series of initiatives aimed at (1) increasing beneficiary insurance information available to Medicare contractors and (2) requiring contractors to use this information to screen claims before payment and to recover Medicare payments made in error. Specifically, HCFA

- compiled data from questionnaires mailed to about 17.5 million Medicare beneficiaries to identify beneficiaries whose employer-sponsored health insurance should be primary to Medicare;
- required contractors to investigate the initial Medicare claims of all 65- to 66-year-olds and disabled beneficiaries for other primary insurance coverage;
- established RDES requiring contractors to collect, document, and share a uniform record of information on beneficiaries with primary insurance coverage;

- required contractors to install prepayment edits in their claims processing systems for checking a beneficiary's primary insurance file; and
- required contractors to use the new RDES and other information to recover amounts previously paid in error.

Our review concentrated on two of these initiatives: (1) contractors' implementation of RDES and (2) their investigation of beneficiaries' initial claims. We found problems with the completeness and quality of the data entered into RDES, the extent to which RDES data were used, and the identification of coverage for new beneficiaries.

Problems With Data Quality

HCFA directed its contractors to obtain and document a complete record on the insurance coverage of each Medicare beneficiary. Starting in April 1987, for each quarter, contractors were instructed to submit computer tapes of these records of beneficiaries having medical insurance to a designated regional processing center. These centers were to screen each contractor's data for completeness and proper format and consolidate the records for all beneficiaries living in that region. The next month, the center would return the consolidated information to each contractor in the region. HCFA directed its contractors to use these RDES data to supplement or replace the beneficiary insurance coverage information contained in their files.

We examined reports prepared by these regional processing centers on the results of the second and third data exchanges made in 1987. For the second exchange, we had reports from all but one of the regional processing centers; for the third exchange, reports were available from all 10 regions. These reports showed that

- over 13 and 15 percent of HCFA's contractors did not submit tapes containing their records of beneficiaries with primary coverage to RDES in the second and third exchanges, respectively, and
- 17 percent of the contractors submitting data in the second exchange and 12 percent in the third exchange had 90 percent or more of their records rejected by RDES edits because records were not complete and/or correctly formatted.

Limited Use of RDES Information

Despite these problems with data quality, RDES has the potential to give contractors information to identify and bill other insurers. We queried five contractors in four regions about the usefulness of the RDES data. One contractor said that RDES data enabled it to identify and suspend

130 claims processed during November 1987 for beneficiaries with other primary insurance coverages. The four others said that RDES data submitted by other contractors in the second and/or third data exchanges in 1987 provided new identifications of insurance coverage for 1,239 additional beneficiaries.

However, based on visits to two of the above contractors that provided us with data and three others, we found that some contractors were making limited use of RDES's information. Although HCFA directed contractors to use this new information in editing beneficiaries' claims for primary insurance coverage, one of the contractors we visited told us it had turned off its claims editing controls for several months to speed up operations, and another told us it was not using RDES data to supplement its database as HCFA required. Although contractors are instructed to recover Medicare claims payments made in error back to a specific time, only one of the five contractors routinely used its RDES information to recover money on its prior overpayments.

In addition, contractors were not complying with HCFA's April 1987 memorandum that instructed regional administrators to direct contractors to identify and recover overpayments made for services furnished after January 1984 to Medicare's aged beneficiaries covered under an employer-sponsored group health plan. To identify these beneficiary claims, the memorandum stated, contractors should use RDES data on the results of HCFA's earlier questionnaire mailing to 17.5 million of Medicare's aged population. Contractors were to identify these overpayments by September 30, 1987; complete recovery of overpayments on working beneficiaries aged 70 and older by December 31, 1987; and complete recoveries on all other aged beneficiaries by September 30, 1988.

To assess contractor compliance, HCFA directed its regional offices to require their contractors to submit monthly progress reports. We asked HCFA's regional offices to provide us copies of all progress reports submitted to them by their contractors during the period May-September 1987. From the reports provided by seven of HCFA's regions, we found:

- Of the 73 contractors, 8 submitted no reports, and 10 submitted reports that identified no potential overpayments. In these reports, some contractors stated that they would not initiate their recoveries under this project until later in fiscal year 1988.
- Contractors were not reporting monthly or correctly as directed by HCFA. Only 14 contractors reported regularly from June through September. The last progress report from 40 of the 65 reporting contractors was

unreliable because it contained readily apparent errors and inconsistencies.

Concerned about compliance with this requirement, in October 1987 HCFA wrote its regional administrators reiterating the importance of contractors' maintaining the established recovery schedule. The letter also clarified and repeated the need for contractors to seek and document recoveries in accordance with HCFA-established policies and procedures. We did not review subsequent progress reports.

Problems With Identifying Coverage for New Beneficiaries

Medicare part B contractors are responsible for determining through questionnaires whether newly eligible beneficiaries have primary insurance coverage before paying their claims. This information is passed on to part A contractors through RDES. While headquarters officials told us HCFA had not required its part B contractors to report their results, we found the contractors in one region were asked by their regional office to keep records on their experiences. These records indicate that the practice of questioning new beneficiaries for insurance coverage is worthwhile. For example, one contractor found indications in the returned questionnaire that 5.3 percent of the disabled and 4.6 percent of the 65- and 66-year-old beneficiaries it queried had other primary insurance coverage.

Based on contractors' and regional officials' questions and comments about this instruction, HCFA officials told us they believe there may be widespread instances of noncompliance. We found evidence of noncompliance during visits to three part B contractors. For example, one contractor was not implementing the instruction, while two others were doing so in ways that may restrict its effectiveness. Contrary to HCFA instructions, one of these contractors paid new beneficiaries' claims as if Medicare were the primary insurer even though the beneficiaries had not returned their insurance coverage questionnaires. Also, neither had implemented HCFA directives to retroactively determine the primary insurance coverage for newly eligible beneficiaries who had filed claims before the instruction's effective date.

Current Performance Standards Not Encouraging Maximum Savings

Medicare contractors have inherent disincentives to make greater use of RDES information because they are also private insurers that stand to save money in cases where Medicare pays claims as primary insurer. HCFA's system for measuring contractor performance does not overcome this inherent disincentive. Specifically, contractors can be rated as successful even though they do not fully adopt or use RDES and other systems and internal control procedure/processes designed by HCFA to help assure contractor success at identifying and billing other insurers that should pay ahead of Medicare.

HCFA's Contractor Performance Evaluation Program sets standards for measuring contractors' performance under the Medicare program. Contractors have incentives to meet the CPEP standards because failure to do so is grounds for not renewing the contract. CPEP contains HCFA standards to measure performance of its contractors in the secondary payer program. The standards are based on HCFA estimates of the total savings its contractors should realize from administering the secondary payer program and its allocation of these amounts in the form of savings goals to each part A and part B contractor. In fiscal year 1987, for example, HCFA estimated total savings at $1 billion and established savings goals for each of its contractors. In fiscal years 1987 and 1988, the CPEP standard called for each contractor to achieve at least 90 percent of its savings goal. In fiscal year 1987, all but 1 of the 109 contractors met their CPEP secondary payer savings standards.

The following examples illustrate how contractors meet their goals but stop short of saving additional amounts when the potential to do so exists.

- One contractor that did not use RDES information did not take advantage of other opportunities to increase its secondary payer savings. For example, an audit by the HHS IG identified $548,363 in Medicare claims that this contractor erroneously paid over a 26-month period as primary payer. In June 1986 the IG furnished the contractor with a listing of the claims, including the name of the primary insurance company involved. The contractor, however, did not begin to seek recoveries from these primary insurers until the workday before our visit in January 1988. In June 1987 this contractor also identified, through a questionnaire, 65 disabled beneficiaries with insurance coverage primary to Medicare, but as of January 1988 an official of this contractor told us that it had taken no action to recover any previous payments made in error. Contractor officials told us they had met their 1986 and 1987 savings goals and

were on schedule to meet their 1988 savings goals. Therefore, the officials told us that they saw little need to pursue extra savings, which at that time, they did not need to meet the CPEP savings goals.

- When it became clear to another contractor in July 1987 that it would meet its fiscal year 1987 secondary payer savings standard, it transferred staff used to identify and apply primary insurance coverage to Medicare claims to other departments, a contractor official told us.

Two other Medicare contractors that were also major private health insurers (discussed on p. 13) had met their savings goal even though, according to the HCFA Administrator's letter to the IG:

- One contractor did not maintain a conventional audit trail for attempted recoveries from its private insurance business. As a result, HCFA was unable to determine whether the contractor complied with HCFA policy and directives in recovering erroneous primary payments.
- The policy of the other contractor's private insurance was not to reimburse Medicare; if followed, then this Medicare contractor was not seeking recoveries or had not referred its private insurance denials to HCFA as required.

In our 1987 report, we identified other instances in which contractors did not do all that they could to identify and bill primary insurers. Consequently, we concluded that HCFA should increase contractor savings standards, if possible, to encourage them to improve their performance. We recognized, however, the practical difficulties confronting HCFA in setting higher standards and in accurately counting realized savings against which contractors' performance is measured. For example, HCFA did not have an accurate means of identifying all Medicare savings realized as a result of providers' obtaining payments from the primary insurer. Thus, we recommended that if HCFA's saving standards could not be set to levels that would be more challenging yet achievable for contractors, then additional process-oriented standards should be established to require contractors to perform specific tasks that are effective in achieving savings.

HCFA did increase its fiscal year 1988 contractors' savings goals over those of 1987. But it did so in a way that will not give contractors an incentive to improve their performance in identifying and applying primary insurance coverage. HCFA's overall CPEP savings goal for fiscal year 1988 is below the level contractors achieved in fiscal year 1987. In fiscal year 1987, contractors reported savings of about $1.3 billion toward

HCFA's savings goal of about $1 billion.[1] While HCFA's goal for fiscal year 1988 is about $1.4 billion, this includes a $212 million goal for the newly covered secondary payer group of disabled beneficiaries with employer group health insurance plans. Excluding this added goal for comparison purposes, HCFA's fiscal year 1988 savings target is about $1.2 billion. To meet their 90-percent standard, contractors need to save about $1.1 billion. Thus, contractors could reduce the level of their fiscal year 1987 savings by about $200 million ($1.3 billion less $1.1 billion), or 16 percent, and still meet their 1988 CPEP standards.

Similar computations for each individual contractor showed that 79 percent of the contractors could reduce their 1988 savings below the level achieved in 1987. In total, these contractors could reduce their savings about 20 percent. On average, the remaining 21 percent of HCFA's contractors, with one exception, would have to increase their savings by only about 6 percent to meet their fiscal year 1988 CPEP requirements.

Basing the increase in each contractor's fiscal year 1988 goal on prior year savings is another reason HCFA's increased savings goals will not improve contractor incentives to maximize savings. Under this approach, contractors that showed the least success in achieving savings had their goals increased substantially less than contractors reporting a higher rate of savings. For example, a contractor that met 98 percent of its fiscal year 1987 savings goals had its 1988 goals increased by 4 percent. On the other hand, a contractor that reported achieving 182 percent of its 1987 goals had its 1988 goals increased by 34 percent. As a result, contractors have an incentive to keep their savings at minimally acceptable levels in the event that future goal increases (and thus, the resulting CPEP standards) might be based on historical achievements.

Conclusions

When insurers do not pay claims that they, not Medicare, should be paying, they save money. Because insurers face no penalty for failing to identify and pay such claims correctly, they have little incentive to establish internal controls that would help assure that they do so. To provide an incentive, the Congress should enact legislation to give HCFA regulatory authority to recover double damages if insurers do not properly treat Medicare as the secondary payer. Such authority would give

[1]Actual reported savings included an additional $131 million representing savings achieved toward a newly established $155 million goal for certain disabled beneficiaries. However, late in fiscal year 1987, HCFA rescinded this goal as a CPEP standard, because, according to HCFA officials, contractors had not been given sufficient notice to react to it.

HCFA a means of penalizing insurers that adopt practices aimed at avoiding primary payment and, in our opinion, serve as a deterrent against such practices.

In January 1987, we reported that Medicare contractors lacked incentives to improve their performance in identifying and billing alternative primary insurance coverage. As HCFA's contractors were also commercial insurers, they had little incentive to maximize the government's savings under the secondary payer program because increased Medicare savings may come, at least in part, at the expense of their own commercial insurance enterprises. HCFA's CPEP did not provide this needed incentive, in part because the performance savings standards HCFA sets were easy for the contractors to meet.

Consequently, we recommended in 1987 that HCFA correct this by adopting one or both of the following options:

1. Increasing contractor CPEP savings standards to set the dollar amount of the standards high enough to be challenging yet achievable.

2. Developing new CPEP standards aimed at measuring the degree to which contractors are effectively implementing and using the systems and methods designated by HCFA to identify and bill primary insurers.

HCFA has not implemented either recommendation. The CPEP savings standards were not materially increased between 1987 and 1988, as we have shown, and these standards remain the only criteria against which contractors' performance in identifying and billing primary payers is measured. HCFA has, however, developed and implemented RDES, which has the potential to improve the data systems and controls contractors have at their disposal to improve their success at assuring that Medicare pays only after beneficiaries' other insurer coverage.

Contractors have few incentives to fully adopt and use RDES and other controls and processes designed by HCFA to help them identify and bill other insurers. HCFA should use CPEP to provide stronger incentives for contractors to make maximum use of RDES to increase savings to Medicare. HCFA could better obtain such assurance if it would establish additional CPEP standards that it could use to directly evaluate the effectiveness with which contractors have implemented and are using RDES.

Recommendation to the Congress

We recommend that the Congress amend the Social Security Act to establish the government's right to collect twice the amounts owed from insurers that do not properly treat Medicare as the secondary payer. Appendix II contains the specific recommended legislative language.

Recommendations to the Secretary of HHS

We recommend that the Secretary direct the Administrator of HCFA to establish CPEP standards and use them to evaluate the effectiveness with which contractors implement and use the controls HCFA designed to prevent Medicare from erroneously paying as the primary payer. These standards should measure the extent to which contractors

- provide to RDES acceptably formatted and complete quarterly data on beneficiaries that have insurance coverage other than Medicare;
- use RDES data to update their insurance files, help prevent future payment errors, and make timely recovery of previous overpayments; and
- comply with HCFA instructions for researching claims of new beneficiaries for private insurance coverage.

Agency Comments

HHS said it strongly supported our recommendations to provide enhanced incentives for providers and insurers to properly identify claims where Medicare is the secondary payer. HHS included our legislative proposal in draft legislation that was sent to the Congress in August 1988. HHS also noted that action was initiated to evaluate contractor use of secondary payer data systems and that validation reviews were expected to begin during 1989. Although HHS did not address whether this action would become, as we specifically recommended, a part of CPEP, such action should enhance contractor compliance. (See app. III.)

Recommended Legislative Language

Section 1862(b) of the Social Security Act should be amended by inserting "(and may, in accordance with paragraph (5) collect double damages)" after "bring an action" in the third sentence of paragraph (1), the second sentence of paragraph (2)(B), and the second sentence of paragraph (3)(A)(ii).

Comments From the Department of Health and Human Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

SEP 27 1988

Mr. Lawrence H. Thompson
Assistant Comptroller General
U.S. General Accounting Office
Washington, D.C. 20548

Dear Mr. Thompson:

Enclosed are the Department's comments on your draft report which discusses the incentives needed to assure Medicare pays after private insurers. The enclosed comments represent the tentative position of the Department and are subject to reevaluation when the final version of this report is received.

The GAO confirms findings of four recent inspections performed by the Office of Inspector General. These inspections show that substantial savings from Medicare secondary payer (MSP) programs are possible through improvements in provider admission screening programs. Accordingly, we strongly support GAO's proposals to provide enhanced incentives for providers and insurers to properly identify MSP situations.

The Department appreciates the opportunity to comment on this draft report before its publication.

Sincerely yours,

Richard P. Kusserow
Inspector General

Enclosure

Comments of the Department of Health and Human Services
on the General Accounting Office Draft Report,
"Incentives Needed to Assure Medicare Pays After Private Insurers"

Overview

According to GAO, Medicare saved about $1.4 billion in Fiscal Year 1987 by paying beneficiaries' medical bills only after other responsible insurers had paid. However, further savings were not achieved because many other such "dual coverage" claims were not identified. GAO explains that neither the Medicare contractors that pay claims nor the other insurers covering Medicare beneficiaries have financial incentives to help ensure that Medicare pays after any other primary payer. GAO believes it is unlikely that Medicare's secondary payer provisions will achieve all possible savings until the program gives contractors and insurers incentives to comply.

We would note that we are examining new ways to promote better up-front identification of cases to which the Medicare secondary payer (MSP) provisions apply. One option we are considering would be to seek authority to require insurers to share information with the Health Care Financing Administration (HCFA) on certain individuals receiving employer group health coverage who are subject to the MSP provisions and on Medicare eligible individuals who have pending liability and workers' compensation claims. In addition, GAO confirms findings of four recent inspections performed by the Office of Inspector General. These inspections show that substantial savings from MSP programs are possible through improvements in provider admission screening programs. Accordingly, we strongly support GAO's proposals to provide enhanced incentives for providers and insurers to properly identify MSP situations.

HCFA believes that matching coverage information from insurers with Medicare records would involve only minimal resources and is an efficient way to identify MSP cases. Improved identification in such a fashion would also minimize the burden on beneficiaries and providers to sort out the complexities of the MSP provisions while resulting in a substantial increase in MSP savings.

GAO Recommendation

To strengthen contractor and other insurer incentives that help assure that Medicare does not pay first when beneficiaries have dual coverage, GAO recommends that:

-- the committees report to the Congress a legislative proposal to amend the Social Security Act, as proposed by the House in 1987, to establish the government's right to collect twice the amounts owed from insurers that do not properly treat Medicare as the secondary payer; and

Department Comment

HCFA strongly supports this legislative proposal and has included it in draft legislation (the Medicare Budget Amendments of 1988) that was sent to Congress on August 8. This draft bill also proposes to strengthen the Federal Government's enforcement capabilities by expanding the statutory provision that allows the IRS to impose a tax on noncomplying employer group health plans (EGHPs) equal to 25 percent of EGHP expenses. Whereas this penalty currently applies only to cases of EGHP noncompliance with the MSP provisions for the disabled, this proposal would extend the penalty to cases of noncompliance with the working aged and end stage renal disease provisions as well.

GAO Recommendation

-- the Secretary of HHS direct the Administrator of HCFA to establish standards for use in evaluating the effectiveness with which contractors implement and use the data systems, processes, and controls HCFA designed to prevent Medicare from erroneously paying as the primary payer.

Department Comment

We concur with this recommendation. We have initiated action to evaluate contractors' use of the Regional Data Exchange System and MSP standardized software. We intend to implement validation reviews in the spring of 1989.

Major Contributors to This Report

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